FOR OHF USE

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0043539

Facility Name: ENFIELD HEALTHCARE CENTER

Address: ONE NORTH WILSON STREET (Number) ENFIELD (City) 62835 (Zip Code)

County: WHITE

Telephone Number: (618) 963-2331 **Fax #** (618) 963-2569

IDPA ID Number: 830320180013

Date of Initial License for Current Owners: 02/07/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: JEFFREY E. BOLAND **Telephone Number:** (717) 213-3125

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) LARRY BONDS

(Title) PRESIDENT

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) JEFFREY E. BOLAND, DIRECTOR

(Firm Name & Address) ZA CONSULTING, LLC
305 NORTH FRONT STREET, HARRISBURG, PA 17101

(Telephone) (717) 213-3125 Fax # (717) 233-4633

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number ENFIELD HEALTHCARE CENTER # 0043539 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,934	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	49	TOTALS	49	17,934	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	10,639	3,815		14,454	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,639	3,815		14,454	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.60%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 2/7/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/7/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ENFIELD HEALTHCARE CENTER # 0043539 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	72,843	5,558	4,566	82,967		82,967	(251)	82,716			1
2	Food Purchase		54,609		54,609		54,609		54,609			2
3	Housekeeping	34,702	6,545	1,350	42,597		42,597		42,597			3
4	Laundry	19,877	3,324	860	24,061		24,061		24,061			4
5	Heat and Other Utilities			34,510	34,510		34,510		34,510			5
6	Maintenance	15,748	4,735	11,870	32,353		32,353		32,353			6
7	Other (specify):*											7
8	**TOTAL General Services**	143,170	74,771	53,156	271,097		271,097	(251)	270,846			8
	B. Health Care and Programs											
9	Medical Director			2,800	2,800		2,800		2,800			9
10	Nursing and Medical Records	280,143	11,705	38,266	330,114		330,114	2,624	332,738			10
10a	Therapy		155	4,051	4,206		4,206		4,206			10a
11	Activities	20,623	528	2,639	23,790		23,790		23,790			11
12	Social Services	14,476		2,371	16,847		16,847	32	16,879			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	315,242	12,388	50,127	377,757		377,757	2,656	380,413			16
	C. General Administration											
17	Administrative			68,360	68,360		68,360	9,280	77,640			17
18	Directors Fees											18
19	Professional Services			1,552	1,552		1,552	18,653	20,205			19
20	Dues, Fees, Subscriptions & Promotions			12,746	12,746		12,746	(8,215)	4,531			20
21	Clerical & General Office Expenses	2,427	7,560	8,348	18,335		18,335	27,626	45,961			21
22	Employee Benefits & Payroll Taxes			40,328	40,328		40,328	40,679	81,007			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,240	3,240		3,240	2,054	5,294			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			18,376	18,376		18,376	12,418	30,794			26
27	Other (specify):*											27
28	**TOTAL General Administration**	2,427	7,560	152,950	162,937		162,937	102,495	265,432			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	460,839	94,719	256,233	811,791		811,791	104,900	916,691			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ENFIELD HEALTHCARE CENTER #0043539 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			22,074	22,074		22,074		22,074			30
31	Amortization of Pre-Op. & Org.			17,992	17,992		17,992	(16,884)	1,108			31
32	Interest			56,112	56,112		56,112		56,112			32
33	Real Estate Taxes			4,414	4,414		4,414		4,414			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,725	5,725		5,725		5,725			35
36	Other (specify):* Mtg. Guarantee			7,208	7,208		7,208		7,208			36
37	**TOTAL Ownership**			113,525	113,525		113,525	(16,884)	96,641			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		3,330	2,453	5,783		5,783		5,783			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			26,902	26,902		26,902		26,902			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		3,330	29,355	32,685		32,685		32,685			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	460,839	98,049	399,113	958,001		958,001	88,016	1,046,017			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ENFIELD HEALTHCARE CENTER # 0043539 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(251)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(8,215)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(15,619)	VAR		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (24,085)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	114,952	VAR	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 114,952		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 90,867		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

ENFIELD HEALTHCARE CENTER

ID# 0043539

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	AMORT - GOODWILL	$ (16,884)	31	1
2	BUSINESS MEALS	(555)	21	2
3	BANK CHARGES	(93)	21	3
4	PRIOR YEAR EXPENSE	(600)	21	4
5	FINES/PENALTIES	(338)	21	5
6				6
7				7
8				8
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11				11
12				12
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84				84
85				85
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89				89
90	**Total**	(18,470)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ENFIELD HEALTHCARE CENTER # 0043539 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(251)	0	0	0	0	0	0	0	0	0	0	(251)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(251)	0	0	0	0	0	0	0	0	0	0	(251)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	2,624	0	0	0	0	0	0	0	0	0	2,624	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	32	0	0	0	0	0	0	0	0	0	32	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	2,656	0	0	0	0	0	0	0	0	0	2,656	16
	C. General Administration													
17	Administrative	0	9,280	0	0	0	0	0	0	0	0	0	9,280	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	18,653	0	0	0	0	0	0	0	0	18,653	19
20	Fees, Subscriptions & Promotions	(8,215)	0	0	0	0	0	0	0	0	0	0	(8,215)	20
21	Clerical & General Office Expenses	(1,586)	1,163	28,049	0	0	0	0	0	0	0	0	27,626	21
22	Employee Benefits & Payroll Taxes	0	0	40,679	0	0	0	0	0	0	0	0	40,679	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,054	0	0	0	0	0	0	0	0	0	2,054	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	12,418	0	0	0	0	0	0	0	0	12,418	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(9,801)	12,497	99,799	0	0	0	0	0	0	0	0	102,495	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(10,052)	15,153	99,799	0	0	0	0	0	0	0	0	104,900	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ENFIELD HEALTHCARE CENTER # 0043539 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	(16,884)	0	0	0	0	0	0	0	0	0	0	(16,884)	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(16,884)	0	0	0	0	0	0	0	0	0	0	(16,884)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(26,936)	15,153	99,799	0	0	0	0	0	0	0	0	88,016	45

Facility Name & ID Number ENFIELD HEALTHCARE CENTER # 0043539 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST		SEE ATTACHED LIST		EDEN & ASSOCIATE	WILSON, WY	CONSULTING

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	Contract Services - RN	$	Senior Living Properties, LLC	100.00%	$ 279	$ 279	1
2	V	10	Contract Services - RN		Senior Living Properties, LLC	100.00%	1,072	1,072	2
3	V	10	Contract Services - RN		Senior Living Properties, LLC	100.00%	1,273	1,273	3
4	V	12	Social Services Consultant	2,371	Senior Living Properties, LLC	100.00%	2,403	32	4
5	V	17	Contract Services - Business Office	24,846	Senior Living Properties, LLC	100.00%	30,945	6,099	5
6	V	17	Contract Services - Administrator	43,515	Senior Living Properties, LLC	100.00%	46,696	3,181	6
7	V	24	Travel	3,088	Senior Living Properties, LLC	100.00%	5,047	1,959	7
8	V	21	Business Meals	555	Senior Living Properties, LLC	100.00%	731	176	8
9	V	24	Seminars	152	Senior Living Properties, LLC	100.00%	247	95	9
10	V	21	Office Supplies	5,587	Senior Living Properties, LLC	100.00%	5,848	261	10
11	V	21	Supplies	623	Senior Living Properties, LLC	100.00%	673	50	11
12	V	21	Postage	1,350	Senior Living Properties, LLC	100.00%	1,360	10	12
13	V	21	Telephone	9,346	Senior Living Properties, LLC	100.00%	10,012	666	13
14	Total			$ 91,433			$ 106,586	$ * 15,153	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ENFIELD HEALTHCARE CENTER # 0043539 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	EDP Services	$ 1,552	Senior Living Properties, LLC	100.00%	$ 4,506	$ 2,954	15
16	V	19	Legal Fees		Senior Living Properties, LLC	100.00%	6,464	6,464	16
17	V	19	Accounting Fees		Senior Living Properties, LLC	100.00%	12,189	12,189	17
18	V	26	Insurance - General Liability	16,239	Senior Living Properties, LLC	100.00%	18,443	2,204	18
19	V	26	Insurance - Property & Contents	2,037	Senior Living Properties, LLC	100.00%	12,160	10,123	19
20	V	26	Insurance - Other	100	Senior Living Properties, LLC	100.00%	191	91	20
21	V	22	Workers Compensation Claims	872	Senior Living Properties, LLC	100.00%	31,881	31,009	21
22	V	22	Health & Dental Insurance		Senior Living Properties, LLC	100.00%	9,670	9,670	22
23	V	21	Management Fees		Senior Living Properties, LLC	100.00%	25,095	25,095	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 20,800			$ 120,599	$ * 99,799	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ENFIELD HEALTHCARE CENTER # 0043539 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ENFIELD HEALTHCARE CENTER # 0043539 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: SENIOR LIVING PROPERTIES,LLC
Street Address: 3395 NORTH PINES DRIVE, SUITE 102
City / State / Zip Code: WILSON, WYOMING 83014
Phone Number: (307) 739-1209
Fax Number: (307) 739-1217

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Contract Services - RN	Resident Days (IL Only)	675,434	31	$ 13,034	$	14,454	$ 279	1
2	10	Contract Services - RN	Resident Days (IL Only)	675,434	31	50,078		14,454	1,072	2
3	10	Contract Services - RN	Resident Days (IL Only)	675,434	31	59,476		14,454	1,273	3
4	12	Social Services Consultant	Resident Days (IL Only)	675,434	31	1,475		14,454	32	4
5	17	Contract Services - Business Offic	Resident Days (Total)	1,728,555	88	729,382		14,454	6,099	5
6	17	Contract Services - Administrator	Resident Days (IL Only)	675,434	31	148,670		14,454	3,181	6
7	24	Travel	Resident Days (IL Only)	675,434	31	91,552		14,454	1,959	7
8	21	Business Meals	Resident Days (IL Only)	675,434	31	8,225		14,454	176	8
9	24	Seminars	Resident Days (IL Only)	675,434	31	4,452		14,454	95	9
10	21	Office Supplies	Resident Days (IL Only)	675,434	31	12,185		14,454	261	10
11	21	Supplies	Resident Days (IL Only)	675,434	31	2,350		14,454	50	11
12	21	Postage	Resident Days (IL Only)	675,434	31	466		14,454	10	12
13	21	Telephone	Resident Days (IL Only)	675,434	31	31,125		14,454	666	13
14	21	EDP Services	Resident Days (IL Only)	675,434	31	138,040		14,454	2,954	14
15	19	Legal Fees	Resident Days (Total)	1,728,555	88	737,379		14,454	6,166	15
16	19	Accounting Fees	Resident Days (Total)	1,728,555	88	1,457,713		14,454	12,189	16
17	26	Insurance - General Liability	Resident Days (Total)	1,728,555	88	263,635		14,454	2,204	17
18	26	Insurance - Property & Contents	Resident Days (Total)	1,728,555	88	1,210,642		14,454	10,123	18
19	26	Insurance - Other	Resident Days (Total)	1,728,555	88	10,924		14,454	91	19
20	22	Workers Compensation Claims	Resident Days (Total)	1,728,555	88	330,015		14,454	2,760	20
21	22	Health & Dental Insurance	Resident Days (Total)	1,728,555	88	1,156,469		14,454	9,670	21
22	21	Management Fees	Resident Days (Total)	1,728,555	88	1,721,509		14,454	14,395	22
23	19	Legal Fees	Resident Days (IL Only)	675,434	31	13,948		14,454	298	23
24	22	Workers Compensation Claims	Resident Days (IL Only)	675,434	31	1,320,062		14,454	28,249	24
25	TOTALS					$ 9,512,806	$		$ 104,252	25

Facility Name & ID Number ENFIELD HEALTHCARE CENTER # 0043539 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: SENIOR LIVING PROPERTIES,LLC
Street Address: 3395 NORTH PINES DRIVE, SUITE 102
City / State / Zip Code: WILSON, WYOMING 83014
Phone Number: (307) 739-1209
Fax Number: (307) 739-1217

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Management Fees	Resident Days (IL Only)	675,434	31	$ 500,000	$	14,454	$ 10,700	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 500,000	$		$ 10,700	25

Facility Name & ID Number ENFIELD HEALTHCARE CENTER # 0043539 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	GMAC COMM MORT CORP		X	ACQUISITION	$2,852.00	2/6/98	$ 392,134	$ 370,775	2/1/08	0.0681	$ 26,691	1
2	CCS NOTE		X	ACQUISITION	$102.00	2/6/98	17,550	17,550	2/6/08	0.0700	7,125	2
3	SEE ATTACHED		X	ACQUISITION	$102.00	2/6/98	17,550	17,550	2/6/08	0.0700	7,125	3
4												4
5												5
	Working Capital											
6	HEALTH CARE FINANCIAL PART		X	WORKING CAPITAL	NONE	2/6/98	33,094	7,455	DEMAND	PRIME + 2%	15,171	6
7												7
8												8
9	TOTAL Facility Related				$3,056.00		$ 460,328	$ 413,330			$ 56,112	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 460,328	$ 413,330			$ 56,112	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ENFIELD HEALTHCARE CENTER # 0043539 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	2,345	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	4,414	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,069	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	2,345	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 2000 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	4,414	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	3,600	8
	1996	3,756	9
	1997	3,911	10
	1998	4,133	11
	1999	4,414	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

Facility Name & ID Number ENFIELD HEALTHCARE CENTER # 0043539 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 10,476 B. General Construction Type: Exterior BRICK & CONCRETI Frame WOOD Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	75,359	1998	$ 2,100	1
2					2
3	TOTALS	75,359		$ 2,100	3

Facility Name & ID Number ENFIELD HEALTHCARE CENTER # 0043539 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	49		1998	1972	$ 189,003	$ 6,300	30	$ 6,300	$	$ 18,375	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CARPET			1998	767	153	5	153		345	9
10	WALLPAPER			1998	1,364	273	5	273		614	10
11	PAINT&REPAIR			1998	2,530	506	5	506		1,223	11
12	INSTALL WATER HEATER			1998	3,600	360	10	360		750	12
13											13
14											14
15	SIGNAGE			1998	464	46	10	46		120	15
16	LAYOUT & LINE PAVMENT			1998	600	40	15	40		97	16
17	PARKING LOT			1998	9,942	1,243	8	1,243		3,003	17
18	REPLACEMENT WINDOWS			1999	300	30	10	30		58	18
19	REPLACEMENT WINDOWS			1999	2,698	270	10	270		517	19
20	DOOR ALARM UPGRADE			1999	2,297	230	10	230		402	20
21	DOOR ALARM PARTS			1999	85	9	10	9		15	21
22	FRONT AWNING			1999	3,428	229	15	229		400	22
23	BATHROOM REMODELING			1999	14,225	948	15	948		1,343	23
24	ANTENNA SYSTEM			1999	1,876	188	10	188		250	24
25	LANDSCAPING & ROCKS			1999	1,420	142	10	142		201	25
26	LANDSCAPING			1999	1,500	150	10	150		175	26
27											27
28	WINDOWS			2000	2,787	62	15	62		62	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 238,886	$ 11,179		$ 11,179	$	$ 27,950	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ENFIELD HEALTHCARE CENTER # 0043539 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 69,754	$ 10,689	$ 10,689	$	VARIOUS	$ 27,031	37
38	Current Year Purchases	7,797	206	206		VARIOUS	206	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 77,551	$ 10,895	$ 10,895	$		$ 27,237	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 318,537	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 22,074	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 22,074	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 55,187	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number ENFIELD HEALTHCARE CENTER # 0043539 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NOT APPLICABLE

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5					NOT APPLICABLE			5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: NOT APPLICABLE *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 5,487 Description: DISHWASHER - $294; COPIER - $114; SCAFFOLDING TRUCK - $5079
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19			NOT APPLICABLE		19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ENFIELD HEALTHCARE CENTER # 0043539 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number ENFIELD HEALTHCARE CENTER # 0043539 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.3	# of prescrpts			513	1,095		1,608	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): ANCILLARY SVCS.	39.2, 39.3				334	3,841		4,175	13
14	TOTAL			$		$ 847	$ 4,936		$ 5,783	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number ENFIELD HEALTHCARE CENTER # 0043539 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 10,960	$	1
2	Cash-Patient Deposits	9,444		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 15,130)	137,627		3
4	Supply Inventory (priced at COST)	11,369		4
5	Short-Term Investments			5
6	Prepaid Insurance	3,410		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 172,810	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,100		13
14	Buildings, at Historical Cost	234,996		14
15	Leasehold Improvements, at Historical Cost	13,926		15
16	Equipment, at Historical Cost	67,515		16
17	Accumulated Depreciation (book methods)	(55,187)		17
18	Deferred Charges	152,121		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 415,471	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 588,281	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 68,994	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,444		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	2,345		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	INTERCO SLP TEXAS	114,274		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 195,057	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	413,330		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 413,330	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 608,387	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (20,106)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 588,281	$	48

*(See instructions.)

Facility Name & ID Number ENFIELD HEALTHCARE CENTER # 0043539 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (55,982)	1
2	Restatements (describe):		2
3	AUDIT ADJUSTMENTS	(3,777)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (59,759)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	39,653	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 39,653	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (20,106)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number ENFIELD HEALTHCARE CENTER # 0043539 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,050,255	1
2	Discounts and Allowances for all Levels	(59,635)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 990,620	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	80	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 80	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,147	13
14	Non-Patient Meals	251	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	5,877	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 7,275	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**OTHER REVENUE**	(321)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (321)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 997,654	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	271,097	31
32	Health Care	377,757	32
33	General Administration	162,937	33
	B. Capital Expense		
34	Ownership	113,525	34
	C. Ancillary Expense		
35	Special Cost Centers	5,783	35
36	Provider Participation Fee	26,902	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 958,001	40
41	**Income before Income Taxes (line 30 minus line 40)****	39,653	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 39,653	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? EXTENDED If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ENFIELD HEALTHCARE CENTER # 0043539 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,745	4,369	55,675	12.74	3
4	Licensed Practical Nurses	6,208	7,243	65,665	9.07	4
5	Nurse Aides & Orderlies	18,842	21,982	141,203	6.42	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,075	3,588	20,623	5.75	10
11	Social Service Workers	1,978	2,308	14,476	6.27	11
12	Dietician					12
13	Food Service Supervisor	1,850	2,158	17,820	8.26	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,915	9,234	55,023	5.96	15
16	Dishwashers					16
17	Maintenance Workers	1,927	2,248	15,748	7.01	17
18	Housekeepers	5,170	6,032	34,702	5.75	18
19	Laundry	2,746	3,204	19,877	6.20	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	362	422	2,427	5.75	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	380	443	2,867	6.47	31
32	Other Health Care(specify)	904	1,055	14,733	13.96	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	55,102	64,286	$ 460,839 *	$ 7.17	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	$ 3,501	1.3	35
36	Medical Director	MONTHLY	2,800	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	MONTHLY	4,051	10a.3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	MONTHLY	2,632	11.3	44
45	Social Service Consultant	MONTHLY	2,371	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 15,355		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number ENFIELD HEALTHCARE CENTER # 0043539 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
CONTRACT SERV - BUS. OFFICE	$ 24,846
CONTRACT SERV - ADMINISTRATOR	43,514
TOTAL (agree to Schedule V, line 17, col. 3)	$ 68,360
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
VARIOUS	EDP SERVICES	$ 1,552
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 1,552

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 31,882
Unemployment Compensation Insurance	8,011
FICA Taxes	31,444
Employee Health Insurance	9,670
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 81,007

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,312
Health Care Worker Background Check	
(Indicate # of checks performed)	252
ADVERTISING - PUBLIC RELATIONS	8,215
PROF DUES/LICENSES	967
Less: Public Relations Expense	(8,215)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,531

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	5,047
Seminar Expense	247
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,294

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ENFIELD HEALTHCARE CENTER # 0043539 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number ENFIELD HEALTHCARE CENTER # 0043539 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **15**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **26,902**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **NO** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **YES** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **IMMATI**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **NO - MINOR**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees